31-008.08A Disclosure of Cost Reports: Cost reports for all report periods ending October 30, 1990, or thereafter, are available for public inspection by making a written request to the Department of Finance and Support, Audit Unit. The request must include the name (including an individual to contact), address, and telephone number of the individual or organization making the request; the ICF/MR name, location, and report period for the cost report requested; and directions for handling the request (review the reports in the Department of Finance and Support; pick up copies from the Department; or mail copies). The total fee, $5.00 handling for each report requested and an additional $5.00 for each report to be copied and an additional $2.50 for each report to be mailed, must accompany the request. The ICF/MR will receive a copy of a request to inspect its cost report.

31-008.08B Descriptions of Form FA-66, "Long Term Care Cost Report": All providers participating in NMAP shall complete Form FA-66, consisting of Schedules "General Data," A (Parts 1 and 2), B (Parts 1, 2, 3, and 4), B-1, B-2, B-3, B-4, B-5, C, D, (Parts 1, 2, and 3), D-1, E (Parts 1 and 2), E-1, F (Parts 1 and 2) and "Certification by Officer, Owner, or Administrator." (See 471-000-41 and 471-000-42 for an example of all schedules.) For FA-66 must be completed in accordance with regulations found at 471 NAC 12-012 ff. Form FA-66 contains the following schedules, as described:

1. General Data: This schedule provides general information concerning the provider and its financial records.
2. Schedule A, Occupancy Data: This schedule summarizes the licensed capacity and inpatient days for all levels of care.
   Part 1 identifies the certified days available, and Part 2 identifies the inpatient census data of the facility. This data is used in determining the divisor in computing the facility's per diem rate.
3. Schedule B, Revenue and Costs: This schedule reports the revenues and costs incurred by the provider. The schedule begins with the facility's trial balance, and identifies revenue offsets, adjustments, and/or allocations necessary to arrive at the NMAP reimbursable costs.
   Part 1 identifies all revenues from patient services and any necessary offsets to costs from these revenues. Part 2 identifies other revenues realized by the facility and any necessary offsets to costs from these revenues. Part 3 identifies the facility's costs, summarizes the revenue offsets, summarizes the cost adjustments, and reports any necessary allocation of reimbursable costs. Part 4 summarizes the revenue and costs reported in parts 1, 2, and 3, and reports net income and identifies provision for income tax.

4. Schedule B-1, General Cost Allocation and Adjustment: This schedule is used when payroll costs and fringe benefits are not specifically identified by cost category on the facility's books. If the trial balance has these accounts identified to the appropriate category, this schedule is not used.
5. Schedule B-2, Transactions with Related Organizations – Report and Adjustments: This schedule identifies facility transactions that are expenditures for services and supplies furnished to the provider by organizations related to the provider by common ownership or control. Interest on loans, depreciation on fixed assets, and leases, with related organizations are reported on other schedules and are not reported on Schedule B-2.
6. Schedule B-3, Compensation of Owners, Directors and Other Related Parties – Report and Adjustment: This schedule identifies salaries/ wages/compensations paid or payable for managerial, administrative, professional, or other services, including amounts paid or payable that are for the personal benefit of the individual or are assets or services of the facility, and removes/reduces such amounts to amounts allowable for reimbursement. All such compensations must be reported even though removal/adjustment is not required.
7. Schedule B-4, Other Cost Adjustments: This schedule identifies all adjustments necessary to adjust costs to the proper category, or to adjust costs to amounts allowable for reimbursement which are not adjusted on other schedules of the report or which are not handled through allocations.
8. Schedule B-5, Statistical Data for Allocations: This schedule identifies the allocation basis used to allocate allowable costs between levels of care and the unallowable costs when direct cost accounting is not used or is impractical to use.
9. Schedule C, Comparative Balance Sheet: This schedule identifies the facility's balance sheet accounts for the previous year end and the current period. Multi-facility operations which maintain balance sheet accounts on a consolidated basis may make a statement to that effect on Schedule C; however, the long-term assets and liabilities sections must be completed for the reporting facility.
10. Schedule D, Depreciation Cost: This schedule identifies summary information on the fixed assets, necessary adjustments to depreciation, and allowable depreciation. Depreciation expense allowed under the NMAP may differ from that allowed for IRS purposes. Limitations may be imposed, and only the straight-line method may be used.

Part 1 identifies data for all fixed assets included on the facility's trial balance, and any adjustments necessary to remove or adjust the assets for computation of reimbursable depreciation. Part 2 identifies all current report period fixed asset additions by line item. Part 3 identifies all current period fixed asset deletions by line item.

11. Schedule D-1, Depreciation Schedule Adjustments: This schedule identifies all adjustments needed to adjust the fixed asset value to amounts for reimbursement purposes.
12. Schedule E, Interest Cost: This schedule identifies loans, adjustments to loan balances, allowable interest expense and the interest expense limitation.
    Part 1 reports data for each loan on which interest is included on the trial balance, and any adjustments necessary to remove or adjust loans for reimbursement purposes. Part 2 computes the interest limitation adjustment necessary to limit loans to 80% of the cost of assets.
13. Schedule E-1, Loan Schedule Adjustments: This schedule identifies each adjustment needed to adjust the provider's trial balance loans to amounts used for reimbursement.
14. Schedule F, Leases: This schedule identifies items that are on long-term lease, and adjusts to actual costs of ownership when necessary.
    Part 1 reports data for each lease, including any necessary adjustment data.
    Part 2 reports the actual costs of the owner.
15. Certification of Officer, Owner, or Administrator; and Preparer Acknowledgement: This schedule attests to the accuracy of the cost report information provided to the Department; the provider is responsible for ensuring the accuracy even if the report is prepared by a third party. The statement must be signed by the owner, an officer, or the administrator of the facility, and must be acknowledged by the preparer as necessary.

31-008.09 Audits: The Department shall perform at least one desk audit and may perform subsequent desk audits and/or a periodic field audit of each cost report. Selection of subsequent desk audits and field audits will be made as determined necessary by the Department to maintain the integrity of the Nebraska Medical Assistance Program. The Department may retain an outside independent public accounting firm, licensed to do business in Nebraska or the state where the financial records are maintained, to perform the audits. Audit reports must be completed on all field audits and desk audits. All audit reports will be retained by the Department for at least three years following the completion and finalization of the audit.

An initial desk audit will be completed on all cost reports. Payment rates are determined after the initial desk audit is completed.

All cost reports, including those previously desk audited but excluding those previously field audited, are subject to subsequent desk audits. The primary period(s) and subject(s) to be desk-audited are indicated in a notification letter sent to the provider to initiate a subsequent desk audit. The provider shall deliver copies of schedules, summaries, or other records requested by the Department as part of any desk audit.

All cost reports, including those previously desk-audited but excluding those previously field-audited, are subject to field audit by the Department. The primary period(s) to be field-audited are indicated in a confirmation letter, which is mailed to the facility before the start of the field work. A field audit may be expanded to include any period otherwise open for field audit. The scope of each field audit will be determined by the Department but must be sufficiently comprehensive to ascertain that the cost report complies with the provisions of this section. The provider shall deliver to the site of the field audit, or an alternative site agreed to by the provider and the Department, any records requested by the Department as part of a field audit.

The Department may not initiate an audit -

1. More than five years after the end of the report period; or
2. On a cost report which has been previously field-audited.

This does not preclude the Department from reopening an audit in accordance with 471 NAC 31-008.13 #1 or initiating an audit in response to a reopening in accordance with 471 NAC 31-008.13 #2 or when grounds exist to suspect that fraud or abuse has occurred.

31-008.10 Settlement and Rate Adjustments: When an audit has been completed on a cost report, the Department shall determine if an adjustment to the rate is required; if necessary, a settlement amount is determined. Payment or arrangements for payment of the settlement amount, by either the Department or the provider, must be made within 45 days of the settlement notice unless an administrative appeal filed within the appeal period is also filed within the 45-day repayment period. (See 471 NAC 31-008.15 for an exception to the 45-day repayment period.) Administrative appeals filed after the 45-day payment period will not stay repayment of the settlement amount. The filing of an administrative appeal will not stay repayments to the Department for audit adjustments not included in the appeal request. If an audit is completed during the applicable rate period, the Department shall adjust the rate for payments made after the audit completion.

The Department shall determine a final adjustment to the rate and settlement amount after the audit is final and all appeal options have been exhausted. Payment for any final settlement must be made within 30 days. If payment is not made, the Department shall immediately begin recovery from future facility payments until the amount due is recovered.

The Department shall report an overpayment to the federal government on the appropriate form no later than the second quarter following the quarter in which the overpayment was found.

31-008.11 Penalties: Under federal law, the penalty for making a false statement or misrepresentation of a material fact in any application for Medicaid payments and for soliciting, offering, or accepting kickbacks or bribes (including the rebate of a portion of a fee or charge for a patient referral) is imprisonment up to five years, a fine of $25,000, or both. Similarly, making a false statement of material fact about conditions or operations of any institution is a felony punishable by up to five years imprisonment, a fine of not more than $25,000, or both.

31-008.12 Appeal Process: Final administrative decision or inaction in the allowable cost determination process is subject to administrative appeal. The provider may request an appeal in writing from the Director of the Department within 90 days of the decision or inaction. The request for an appeal must include identification of the specific adjustments or determinations being appealed and basis and/or explanation of each item. See 471 NAC 2-003 and 465 NAC 2-006 for guidelines for appeals and fair hearings.

After the Director issues a determination in regard to the administrative appeal, the Department will notify the facility of the final settlement amount. Repayment of the settlement amount must be made within 30 days of the date of the letter of notification.

31-008.13 Administrative Finality: Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

"Reopening" means an action taken by the Director to reexamine or question the correctness of a determination or decision that is otherwise final. The Director is the sole authority in deciding whether to reopen. The action may be taken -

1. On the initiative of the Department within the three-year period;
2. In response to a written request from a provider or other entity within the three-year period. Whether the Director will reopen a determination, which is otherwise final, depends on whether new and material evidence has been submitted, a clear and obvious error has been made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions; or
3. Any time fraud or abuse is suspected.

A provider does not have the right to appeal a finding by the Director that a reopening or correction of a determination or decision is not warranted.

31-008.14 Sanctions: Failure to comply with any repayment provisions will result in immediate suspension of payments as outlined in 471 NAC 2-002 ff., except that the Department is not required to give 30 days notice.

31-008.15 Change of Holder of Provider Agreement: A holder of a provider agreement receiving payments under this section must notify the Department 60 days prior to any change or termination regarding the holder of the provider agreement. If any known settlement is due the Department by that provider, payment must be made immediately. If the provider is subject to recapture of depreciation on the anticipated sale and/or if an audit is in process, the provider will be required to provide a guarantee of repayment of the Department's estimated settlement either by payment of that amount to the Department, providing evidence that another provider receiving payments under this section has assumed liability, or by surety bond for payment. All estimated or final amounts, regardless of appeal status, must be paid before the transfer of ownership.

The Department will not enter into a provider agreement with a new provider if there is an unpaid settlement payable to the Department by a prior provider of services at the same facility unless the new provider has assumed liability for the unpaid amount. Parties to a facility provider change may receive information about unpaid settlement amounts owed to the Department by making a written request.

31-009 through 31-009.04 (Reserved)